MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Pharmacy

December 2005 • Bulletin 620

Contents

Policy Revisions to the 2005 HCPCS Update, Effective November 1, 2005

Medi-Cal policy for the 2005 Healthcare Common Procedure Coding System (HCPCS) National Level II codes was published in previous *Medi-Cal Updates*. The changes that follow are effective for dates of service on or after November 1, 2005.

Reimbursement Adjustments for Select Durable Medical Equipment and Prosthetic Appliance HCPCS Codes

Due to recent corrections to the Medicare rates for HCPCS codes E0971, E1038, E1039 and L5685, Medi-Cal reimbursement rates have also been adjusted. Claims paid for the following HCPCS codes for dates of service on or after November 1, 2005 will be automatically reprocessed.

HCPCS Code	Rental Rate	Purchase Price
E0971	$ 4.34	$ 43.39
E1038	18.03	216.36
E1039	34.20	410.40
L5685	N/A	80.66

HCPCS code L5685 is not reimbursable to podiatrists, and is limited to two in six months.

Reimbursement Restrictions for Power Wheelchair Accessories

HCPCS codes E2368 (power wheelchair component, motor, replacement only) and E2369 (power wheelchair component, gear box, replacement only) are not reimbursable when billed for the same month of service as code E2370 (power wheelchair component, motor and gearbox combination, replacement only).

This information is reflected on manual replacement pages dura cd 9 and 20 (Part 2) and ortho cd2 7 (Part 2).

2006 CPT-4/HCPCS Code Update Reminder

The 2006 updates to the *Current Procedural Terminology*, Fourth Edition, (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) Level II codes become effective for Medicare on January 1, 2006. The Medi-Cal program has not yet adopted the 2006 updates. Do not use 2006 codes to bill for Medi-Cal services until notified to do so in a future *Medi-Cal Update*.

Provider Restrictions for O & P Reimbursement

Providers are reminded that effective for dates of services on or after October 1, 2003, only physicians, podiatrists, certified orthotists and prosthetists may be reimbursed for orthotic and prosthetic appliances. Codes with double asterisks (**) in the *Orthotic and Prosthetic Appliances: Billing Codes and Reimbursement Rates — Orthotics* section of the provider manual are also reimbursable to pharmacists.

Coding Update for Blood Clotting Factor Disorder Products

Effective for dates of service on or after September 1, 2005, Medi-Cal will reimburse the following blood derivative anti-hemophilia codes:

HCPCS Code	Description	Max U/V/S
J7197	Antithrombin III (human) per IU	01
J7198	Anti-inhibitor, per IU	01
Q0187	Factor VIIa per 1.2mg	01
Q2022	Von Willebrand factor (complex) per IU	01

The following HCPCS codes may also be billed using product trade names as the descriptors: J7197 includes "Thrombate III, Atnativ"; J7198 includes "Autoplex T, Feiba VH Immuno"; and code Q0187 may be called "NovoSeven." All of these codes must be billed "By Report" with the appropriate HCPCS code and a copy of the invoice attached to the claim.

Factor VIIa (HCPCS code Q0187) was previously billed with HCPCS code Z5230. Effective for dates of service on or after September 1, 2005, HCPCS Z5230 may not be used to bill Factor VIIa.

Antithrombin III (human) was previously billed with HCPCS code Z5204 and reimbursed at acquisition cost plus. For dates of service on or after September 1, 2005, providers must bill Antithrombin III (human) with HCPCS code J7197, which will be reimbursed at the Average Selling Price (ASP) plus 20 percent.

This information is reflected on manual replacement pages blood 1 and 2 (Part 2), blood hcfa 1 thru 4 (Part 2) and cal child ser 15 and 16 (Part 2).

Reminder that Prosthetic Burn Garments Require a TAR

Providers are reminded that custom fabricated compression burn garments (HCPCS codes A6501 – A6511) require *Treatment Authorization Requests* (TARs) and they are prosthetic codes billed "By Report." Additional prior authorization information for prosthetic suppliers is located in provider manual section *Orthotic and Prosthetic Appliances*.

Presumptive Eligibility Change of Address

Effective immediately, the address for the Presumptive Eligibility (PE) section has changed. Please send all PE forms to the new address:

Department of Health Services
Presumptive Eligibility Support Unit
MS 4607
P.O. Box 997417
Sacramento, CA 95899-7417

The updated information is reflected on manual replacement pages presum 10, 12, 15 and 21 (Part 2).

New CCS Service Code Grouping 09 for Chronic Dialysis Clinics

Chronic Dialysis Clinics are identified with unique Service Code Grouping (SCG) 09 to facilitate the diagnosis and treatment of California Children's Services (CCS) clients, effective retroactively for dates of service on or after July 1, 2004. SCGs allow providers to submit a single code on a Service Authorization Request (SAR) that represents a wide range of services. If the SAR is approved, all codes in the Service Code Grouping identified on the SAR are reimbursable.

The updated information is reflected on manual replacement page cal child ser 22 (Part 2).

CCS Service Code Groupings Update

A number of codes have been added and deleted from the Service Code Grouping (SCG) tables for the California Children's Service (CCS) program. In addition, for provider convenience each added or deleted code is accompanied by a symbol that relates directly to each code's effective date. Codes with a † have an effective date of October 18, 2004, while codes with a †† have an effective date of November 1, 2005. Codes without a symbol are effective July 1, 2004. Codes marked for deletion also have a line through each code.

The updated information is reflected on manual replacement pages cal child ser 1, 3 thru 17 and 20 (Part 2).

Human Papillomavirus DNA or RNA Test Restrictions Update

This is a clarification to an article published in the October 2005 Medi-Cal Update. Effective for dates of service on or after November 15, 2005, new reimbursement requirements were initiated for Human Papillomavirus (HPV) test code 87621 (infectious agent detection by nucleic acid [DNA or RNA]; papillomavirus, human, amplified probe technique).

Family PACT and Medi-Cal providers must bill CPT-4 code 97621 with one of the ICD-9 codes below. Only Family PACT providers must bill CPT-4 code 87621 with a primary diagnosis "S" code in addition to one of the below ICD-9 codes. Claims for dates of service on or after November 15, 2005 for CPT-4 code 87621 that were billed by Family PACT providers without the primary "S" diagnosis code and were denied for an incorrect diagnosis code will need to be resubmitted by those providers with an appropriate primary diagnosis "S" code as well as one of the ICD-9 codes below in order to be reimbursed.

HPV test codes 87620 (infectious agent detection by nucleic acid [DNA or RNA]; papillomavirus, human, direct probe technique) and 87622 (…papillomavirus, human, quantification) referenced in the October 2005 *Medi-Cal Update* were deleted previously from the Family PACT program effective for dates of service on or after April 30, 2004 (April 2004 *Medi-Cal Update*).

Reimbursement of HPV screening is supported for women who qualify to receive the following services:

- Reflex testing for high-risk types of HPV in women with an ASC-US Pap smear, as an alternative to repeat cervical cytology or colposcopy, when a liquid-based cytology collection method has been used.
- Follow-up of Low-grade Squamous Intraepithelial (LSIL) cytology result in women less than 21 years of age (HPV DNA testing at 12 months in lieu of cytology at six and 12 months is an option).
- Follow-up post colposcopy in women with Paps read as Atypical Squamous Cell, High Grade (ASC-H), LSIL, or HPV DNA positive Atypical Squamous Cells of Undetermined Significance (ASC-US) in whom Cervical Intraepithelial Neoplasia (CIN) is not identified at colposcopy (may be followed up at 12 months with HPV DNA testing in lieu of cytology at six and 12 months).
- Follow-up of women with biopsy proven CIN I (HPV DNA testing at 12 months in lieu of cytology at six and 12 months is an option).
- Follow-up in women post treatment of CIN II and III (HPV DNA testing at least six months after treatment in lieu of three follow-up Pap smears is an option).

Please see **HPV**, *page 4*

HPV *(continued)*

Code 87621 may be billed with modifier -26, - TC or -ZS and is reimbursable once every 12 months, any provider, for female recipients 15 years of age or older when billed concurrently with one of the following ICD-9 codes:

ICD-9 Code	Description
233.1	Carcinoma in situ of breast and genitourinary system; cervix uteri
622.11	Dysplasia of cervix (uteri); mild dysplasia of cervix
622.12	Dysplasia of cervix (uteri); moderate dysplasia of cervix
795.01	Papanicolaou smear of cervix with atypical squamous cells of undetermined significance (ASC-US)
795.02.1	Papanicolaou smear of cervix with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H)
795.03	Papanicolaou smear of cervix with low grade squamous intraepithelial lesion (LGSIL)
795.05	Cervical high risk human papillomavirus (HPV) DNA test positive

The revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual will be issued in a future *Updated Information.*

Family PACT
Planning • Access • Care • Treatment

Begin using the PM 330 now for sterilizations scheduled on or after February 1, 2006.

New Sterilization Consent Form for Family PACT Providers Coming Soon

Effective for dates of service on or after February 1, 2006, claims submitted by Family PACT providers for elective sterilizations (CPT-4 codes 55250, 58600, 58615, 58670, 58671, 00851 or 00921) must adhere to all Medi-Cal policies described in the *Sterilization* section of the Part 2 provider manual, including submission of a Department of Health Services sterilization *Consent Form* (PM 330). Use of the PM 330 also includes the following policy updates:

- Recipients must be a minimum of 21 years of age.
- A minimum 30-day waiting period between the recipient's consent and the date of the sterilization procedure is required.

Claims for elective sterilization from Family PACT providers for dates of service prior to February 1, 2006 must continue to follow current Family PACT policy as applied to the sterilization *Consent Form* (PM 284).

The revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) will be issued in a future *Updated Information*. For more information regarding Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555.

Family PACT
Planning • Access • Care • Treatment

Provider Orientation and Update Sessions

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The dates for the first quarter of 2006 are listed below.

Group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Please see **Family PACT**, *page 5*

Family PACT *(continued)*

Office staff members, such as clinic managers and receptionists, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Please note the upcoming Provider Orientation and Update Sessions below.

January 23, 2006	**March 20, 2006**
Department of Health Services Auditorium	**Department of Health Services Auditorium**
1500 Capitol Avenue	1500 Capitol Avenue
Sacramento, CA 95814	Sacramento, CA 95814

For a map and directions to the DHS Auditorium, go to the Family PACT Web site at **www.familypact.org** and click "map" under "Orientation Sessions."

Registration
To register for an Orientation and Update session, go to the Family PACT Web site at **www.familypact.org**, click the appropriate date under "Orientation Sessions" and print out a copy of the registration form. Fill out the form and fax it to the Office of Family Planning at (916) 650-0468.

If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228). Providers must supply the following:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

Check-In
Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present the following:

- Medi-Cal provider number
- Medical license number
- Photo identification

Note: Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

Certificate of Attendance
Upon completion of the orientation session, each prospective new Family PACT medical provider is mailed a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not be mailed a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

Contact Information
For more information regarding the Family PACT Program, please call 1-877-FAMPACT or visit the Family PACT Web site at **www.familypact.org**.

The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

Medi-Cal Now Accepts Part B Pharmacy Crossover Claims

Medi-Cal now accepts Medicare Part B Pharmacy crossover claims for drugs in the HIPAA-mandated NCPDP 1.1 batch format. Retail pharmacy providers or submitters who bill Medicare using the NCPDP format can stop billing the Medi-Cal portion of their crossover claims via the *HCFA 1500* claim form using HCPCS codes. These claims should cross over automatically from CIGNA Medicare. NCPDP claims that do not cross over automatically must be billed to Medi-Cal using the *Pharmacy Claim Form* (30-1) or the *Compound Drug Pharmacy Claim Form* (30-4) in order to accommodate the National Drug Codes (NDCs).

Payment for each service on a Medicare Part B Pharmacy drug crossover claim is calculated using the Medi-Cal rate on file for the NDC number and the quantity billed minus the Medicare payment. Medi-Cal has discontinued payment of the full coinsurance and deductible billed on the claim to make payment on these claims consistent with other crossover claims.

Electronic claims from Medicare with NDC numbers not on the Medi-Cal file must be submitted by the provider on paper and will suspend for a manual review. If the NDC is not found in the Medi-Cal file, the Medicare rate will be used to price the crossover claim if it is determined that the NDC is valid.

Any Medicare Part B pharmacy crossover claim for drugs submitted to Medi-Cal that should be directed to a County Organized Health Systems (COHS) is denied. These claims are not transferred to a COHS for payment like other Medicare Part B crossover claims. All providers must bill COHS separately.

Providers or submitters who have not converted to the NCPDP 1.1 format with Medicare must continue billing the Medi-Cal portion of a crossover claim that is not processed automatically. In that case, providers must use the *HCFA 1500* claim form and HCPCS codes instead of NDCs.

For crossover claim billing instructions and examples, please refer to the *Medicare/Medi-Cal Crossover Claims: Pharmacy Services* section in the Part 2 *Pharmacy* manual.

For more information, call the Telephone Service Center (TSC) at 1-800-541-5555, select the appropriate language option and press option number 14 (includes Medicare/Medi-Cal crossover claims), then 11 (specific to Medicare/Medi-Cal crossover claims).

DRUG USE REVIEW
Educational Information

FDA Warnings of Suicidal Behavior in Children Taking Antidepressants or Atomoxetine

In September 2005, the Food and Drug Administration (FDA) released a public health advisory warning (similar to the warning released in 2004 regarding all antidepressant medications) of suicidal thinking and behavior in children and adolescents. This article summarizes the clinical trial data and information released by the FDA on atomoxetine and antidepressants, and provides utilization data on the use of these agents in the Medi-Cal pediatric population.

I. Suicidality with Atomoxetine

The FDA and its Pediatric Advisory Committee recently requested an analysis of adverse event data from Eli Lilly's atomoxetine database and clinical trials. The FDA's request for this review was prompted by prior findings that antidepressants pose an increased risk of suicidal thoughts and behavior in children taking them. The analysis of atomoxetine data identified a statistically significant increased risk of suicidal thoughts among atomoxetine-treated children and adolescents as compared to placebo groups (4 per 1,000 patients in the atomoxetine group compared to none in the placebo group). There was one suicide attempt observed in among a total of 2,200 patients, and this patient was in the atomoxetine-treated group.

On September 29, 2005, the FDA issued a Public Health Advisory to alert patients and medical professionals of reports of suicidal thinking in children and adolescents taking atomoxetine. The FDA directed Eli Lilly to add a "boxed" warning on the labeling, and to create a medication guide for pharmacists to distribute with all new and refill prescriptions of atomoxetine for children/adolescents.

Please see **FDA Warnings**, *page 7*

FDA Warnings *(continued)*

The FDA advised that upon starting treatment with atomoxetine or changing dose of the drug, pediatric patients must be closely monitored for a few months for the advent of the following signs/symptoms:

- Clinical worsening
- Unusual changes in behavior
- Agitation, irritability
- Suicidal thinking or behavior

It is not yet known if the suicidality in children/adolescents is a phenomenon that extends to the traditional ADHD medications. In early 2006, the FDA plans to complete an ongoing review of side effect data for all ADHD medications.

II. In 2004 the FDA Issued a Black Box Warning Regarding Suicidality in Children and Adolescents with All Antidepressants

On September 16, 2004, the FDA released the following recommendations made by the Psychopharmacologic Drugs and Pediatric Advisory Committees:

- Concluded that increased risk of suicidality in pediatric patients applied to all the drugs studied (fluoxetine, sertraline, mirtazapine, paroxetine, venlafaxine, citalopram, bupropion, fluvoxamine, nefazodone) in controlled clinical trials
- Recommended that warnings of increased risk of suicidality in pediatric patients be applied to all antidepressant drugs
- Recommended a "black-box" warning and endorsed a Medication Guide with every prescription for this class of drugs
- Recommended that the products not be contraindicated because access to these therapies are important

On October 15, 2004, the FDA announced its decision to require a "Black Box Warning and Medication Guide" for the use of all antidepressants in children and adolescents under 18 years of age. New warning language did not prohibit the use of antidepressants in children and adolescents. It only warned of the risk of suicidality and encouraged providers to balance this risk versus benefit. The approved medication guide can be obtained at **www.fda.gov/cder/drug/antidepressants/MG_template.pdf**.

III. How Are Medi-Cal Providers Impacted?

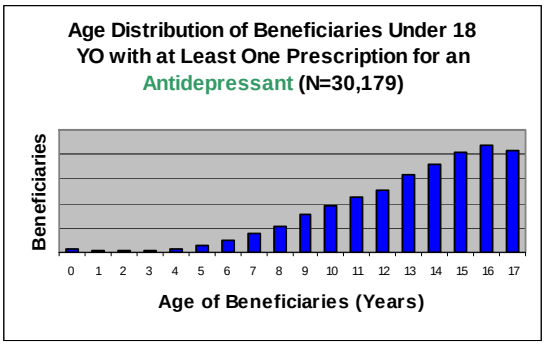
The FDA has issued two warnings to alert medical professionals of reports of suicidal thinking and behavior in children and adolescents taking antidepressants and atomoxetine. Between September 2004 and September 2005, a large number of Medi-Cal recipients were being treated with these agents. Therefore, it is important to properly counsel and closely monitor all pediatric patients who are starting new therapy with these agents, those who are titrating dosage and those with a predisposition/history of bipolar disorder.

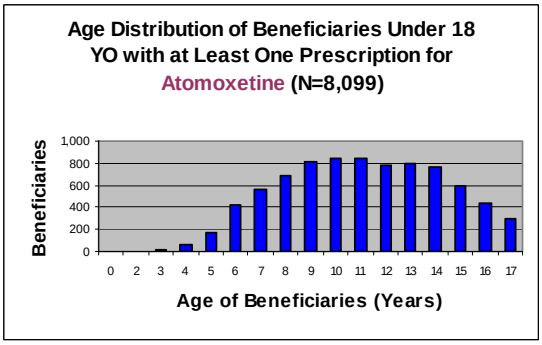
Medi-Cal is actively monitoring the impact that the label changes have made to antidepressants and atomoxetine on the utilization of these drugs and clinical outcomes.

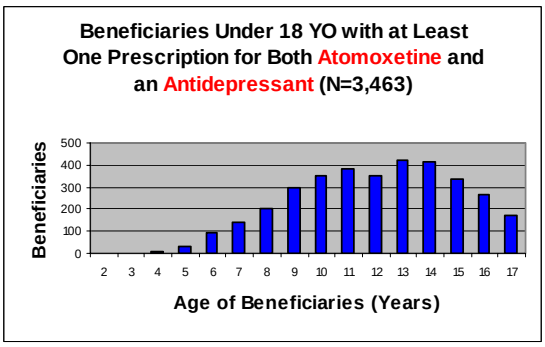
Please see **FDA Warnings**, *page 8*

FDA Warnings *(continued)*

To report any unexpected adverse events associated with these agents, contact the FDA MedWatch program at 1-800-FDA-1088; by fax at 1-800-FDA-0178; by mail to MedWatch; Food and Drug Administration; HFD-410; 5600 Fishers Lane; Rockville, MD 20857-9787; or online at **www.fda.gov/medwatch/report.htm**.







Please refer to pages 36-26 and 27 in the Medi-Cal Drug Use Review Manual.

Instructions for Manual Replacement Pages — Part 2

December 2005

Pharmacy Bulletin 620

Remove and replace:	*Contents for Pharmacy Billing and Policy* iii/iv *
	blood 1/2
	blood hcfa 1 thru 4
	cal child ser 1 thru 22
	dura cd 9/10, 19/20
Insert new section after *Durable Medical Equipment (DME): Billing Examples:*	enteral 1/2 *
Remove and replace:	medi non hcp 1 thru 3 *
	ortho cd2 7/8
	presum 9 thru 12, 15/16, 21

DRUG USE REVIEW (DUR) MANUAL

Remove from the *Education* section:	36-25
Insert:	36-25 thru 27 *(new)*

* Pages updated due to ongoing provider manual revisions.